GENERAL INFORMATION

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General Information

Introduction

This manual will help you prepare insurance benefits paperwork and documentation required by the Employee Insurance Program (EIP). It outlines all of the rules, regulations, policies and guidelines. It includes some of the forms you will use to administer the benefits offered by EIP.

During the year, you may receive updates and/or clarifications to the contents of the manual in the form of insert pages. These pages will either replace or add to the existing pages. They will be numbered and have a revision date. Insert revisions to the manual promptly to ensure proper benefits administration.

Remember, this manual outlines policies and procedures. When determining benefits, the actual *Plan of Benefits Document* supersedes all other publications.

How to use This Manual

The manual has been divided into smaller tabbed sections. In addition to the manual's main Table of Contents, each section has its own Table of Contents to make locating important information easier.

What's New for 2002

The State Health Plan (SHP) implemented the Mental Health Parity with APS Healthcare, Inc., administering the program (Page 22).

CIGNA Healthcare of South Carolina and HMO Blue not available for 2002.

Upstate Partners available in the upstate (Page 191).

In the Beginning

The South Carolina Budget and Control Board created the Office of Insurance Services June 5, 1989. Supporting the board through its executive director, the office manages insurance benefits for state agency, public school district and local subdivision employees, both active and retired, and their dependents.

Acronyms Used in this Manual

Acronym	Explanation
AD&D	Accidental Death & Dismemberment
BA	Benefits Administrator
BCBS	Blue Cross and Blue Shield of South Carolina
BLTD	Basic Long Term Disability
CG	Comptroller General
COBRA	Consolidated Omnibus Budget Reconciliation Act
DEFRA	Deficit Reduction Act
DIGS	Department of Insurance, Grants and Services (effective June 2002)
DIS	The Division of Insurance Services, used prior to 1994 (see also OIS)
EIP	Employee Insurance Program (effective July 2001)
ERISA	Employee Retirement Income Security Act
HIAA	Health Insurance Association of America
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
SHDR	Stanley, Hunt, DuPree, Rhine and Associates (MoneyPlu$)
LE	Late Entrant
LTC	Long Term Care
LTD	Long Term Disability
LWOP	Leave without Pay
NOE	Notice of Election form
OIS	Office of Insurance Services, used since 1994 (see also DIS)
PCP	Primary Care Physician
PDP	(State Health Plan) Prescription Drug Program
Plan	State Health Plan
SCRS	South Carolina Retirement Systems
SHP	State Health Plan
SLTD	Supplemental Long Term Disability
SSN	Social Security Number
TEFRA	Tax Equity and Fiscal Responsibility Act
TERI	Teacher and Employee Retention Incentive Program

Definitions

Active Employee: All permanent, full-time employees who work at least 30 hours per week continuously for more than one year and receive compensation from a department, agency, board, commission or institution of the state, a public school district, a participating local subdivision or other eligible entity.

Active Employment: An employee is performing all the regular duties of his occupation at an established business location of the employer or another location to which he may be required to travel to perform the duties of his employment. An employee is engaged in active employment on normal holidays or vacation days of the employer if the employee was engaged in active employment on the last preceding regular working day. In no event will an employee be considered to be in active employment if he is not physically able to perform all the duties of his employment or if he has effectively terminated employment.

Administrative or Clerical Error: An omission, mistake, misreading or delay in the entry, recording, reproduction or reporting of information in the files relating to the operation of the state benefits programs and made by the plan administrator, BA, claims processor or utilization review agency.

Annual Enrollment: A period when eligible employees and retirees may change health plan carriers only (switch from the State Health Plan Economy plan to Standard plan or vice versa, from the State Health Plan to an HMO or vice versa, or from one HMO to another HMO). Employees can make no other health and/or State Dental Plan changes. Annual enrollment is held every year. Health plan carrier changes are allowed each annual enrollment period with the exception of retirees changing to or from the Medicare Supplemental plan. Employees may enroll in or cancel MoneyPlu$ pre-tax premium feature and must re-enroll in (make changes in their options) the spending accounts. Other program changes may be made as announced.

Beneficiary: The recipient of funds, property or other benefits, as from an insurance policy or will.

Benefit Year: A period of 12 consecutive months, commencing with the first day of January and ending with the last day of December.

Birthday Rule: If dependent children are covered under separate plans, the plan that is primary is the one carried by the person whose birthday (month and day) is earlier in the year. If both insured individuals have the same birthday, the plan that has been in force longer will be primary. Special rules apply to children whose parents are divorced or separated.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985): Requires that continuation of group insurance coverage be offered to subscribers and dependents who lose their health or dental coverage due to a qualifying event.

Coordination of Benefits: Subscriber coverage includes a coordination of benefits provision. It applies whenever a subscriber has claims for health care expenses that also are covered under another group insurance program. In such cases, one of the groups will be primary. The primary carrier pays its covered expenses first. The secondary carrier may pay the remaining covered expenses, but not more than the limits of its coverage or more than the subscriber's actual charges.

Covered Employee: An employee or retiree who has met the eligibility requirements, is enrolled under a plan and to whom benefits are payable under the plan.

Covered Person: An employee, retiree, survivor or COBRA participant, or their dependents, who have met the eligibility requirements, are enrolled under a Plan and to whom benefits are payable under the Plan.

Creditable Coverage: Prior coverage under a health plan, or insurance coverage or health benefits provided by certain state and federal statutes, as described or defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Creditable coverage may be used to reduce a pre-existing condition limitation provided the prior coverage is continuous (prior coverage is considered continuous if the break in coverage is 62 days or less).

Date of Hire: The date an employee physically reports for work.

Dependent: The spouse of an employee or retiree, as long as the spouse is not eligible for coverage under the Plan as an employee or retiree of the state of South Carolina (exceptions may apply). The unmarried children of an employee or retiree, if the employee or retiree is financially responsible for them, through age 18, or if they are full-time students, through age 24 (unless the child is incapacitated). These include natural children, stepchildren, adopted children, foster children and children for whom an employee has conservatorship. The employee or retiree and dependent must be living in a parent/child

relationship or the employee or retiree must be court-ordered to carry the dependent. This includes ex-spouses who are covered by a court order (an ex-spouse and current spouse cannot be covered under the same program).
Note: A court order to carry a dependent child and/or spouse does not mandate the state to carry the dependent, but does allow the court-ordered state employee to place or keep the dependent under his coverage.

Effective Date of a Covered Person: The date on which such person is first covered under a plan.

Effective Date of a Plan: The date on which a plan takes effect.

Employer: An eligible department, agency, board, commission or institution of the state, including the General Assembly; the state courts; school districts and participating local subdivisions that hire and provide compensation to an employee.

Enrollment Date: (1) The hire date for employees; (2) the effective date of coverage for people who enroll under special eligibility situations and late entrants; and (3) the retirement date for retirees.

Entity: An organization that participates in the state insurance benefits program. It is usually used with "participating" to denote the various types of organizations.

Family: A covered employee, his spouse who is not a state employee, and his covered dependents, if any.

Family Status Change: A family status change is an occurrence that allows a subscriber to make changes in his coverage (certain restrictions may apply). Examples include (but are not limited to) divorce, moving out of the service area of an HMO, a dependent child gains employment with benefits, a dependent child becomes ineligible because of age, a dependent child (age 19 –24) regains eligibility by returning to full-time student status, the subscriber is placed under a court order to cover a dependent, the subscriber and/or dependents loss or gain of other coverage, etc.

Full-time Employee: A permanent employee who works at least 30 hours per week continuously for more than one year.

Full-time Student: A dependent child who is age 19 through 24 and is enrolled in and attending school in a full-time student status as defined by the rules of the institution.

Late Entrant: A full-time employee and/or any of his eligible dependents who does not enroll within 31 days of the date first eligible for enrollment and who subsequently enrolls in the plan during an open enrollment period. A late entrant is subject to the pre-existing condition exclusion for 18 months after coverage commences. Any person who qualifies for enrollment under special eligibility situations and meets those requirements, or who becomes eligible for retirement under the South Carolina Retirement Systems, shall not be considered a late entrant if enrolled or re-enrolled in the plan within the time period provided by the plan.

Local Subdivision: Any participating entity covered by local rather than state jurisdiction. Local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government that participate in the program.

Medically Necessary: Services or supplies ordered by a physician to identify or treat an illness or injury. Services and supplies must be provided according to proper, prevailing medical practice in the medical specialty or field at the time the patient receives the service and in the least costly setting required by the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribed a service or supply does not necessarily make it medically necessary.

Open Enrollment: A period in which employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage, and add or drop their eligible dependents in a health plan and/or the State Dental Plan without regard to any special eligibility situations. An open enrollment period will be held in October of years ending in an odd number. Enrollment changes will become effective the following January 1. Other program changes may be made as announced.

Permanent, Part-time Teacher: An academic employee of a South Carolina public school, the South Carolina Department of Juvenile Justice or the South Carolina Department of Corrections whose contract qualifies him for state health and dental benefits is considered a permanent, part-time teacher. He must work at least 15 hours but less than 30 hours per week. The part-time contract position must meet specific guidelines as defined by the Department of Education.

Pre-certification (or Certification): The procedure through which a covered person may obtain a determination from the utilization review agency that a proposed treatment, and length of stay determination, if required, is consistent with generally recognized medical standards and procedures.

Pre-existing Condition: Any medical condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed health care provider or practitioner in the six months preceding the covered person's enrollment date in the Plan. Benefits for a pre-existing condition are payable only for treatment rendered 12 months after the enrollment date of a covered person or 18 months after the enrollment date for a late entrant. Certification of prior continuous coverage (coverage with a break of no more than 62 days prior to the enrollment date) can be applied toward the waiting period for services related to a pre-existing condition to be payable. Pregnancy does not constitute a pre-existing condition.

Providers: Those who render health care services (i.e., hospital, physician, certified nurse midwife, mental health care provider) as those terms are defined in the *Plan of Benefits Document*.

Retiree: An employee who is retired and meets eligibility requirements in order to participate in the state's plan of benefits.

Significant Break in Coverage: A period of 63 or more consecutive days during all of which the individual does not have any creditable coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

Special Eligibility Situation: A special eligibility situation is an event that allows an eligible employee, retiree, survivor or COBRA participant to enroll himself only or any eligible dependents (subscriber must be on plan or added with dependents) in the State Health Plan and/or the State Dental Plan (certain restrictions may apply). Active subscribers participating in the MoneyPlu$ Premium Pre-tax Feature may select, increase, decrease or cancel Optional Life coverage if the special eligibility situation warrants the requested change. Birth, marriage, and adoption or placement are qualifying special eligibility situations.

An involuntary loss or gain of coverage is a qualifying family status change; however, only those who lose or gain coverage may be enrolled in or dropped from a State Health Plan and/or the State Dental Plan.

State-covered Entity: Any state agency, public school district, participating county or any other participating local subdivision granted the right by the General Assembly to participate in the state's plan of benefits.

Subscribers: All active and retired employees, survivors and COBRA participants of state agencies, public school districts, participating local subdivisions and other eligible entities.

Teacher and Employee Retention Incentive Program (TERI): Allows SCRS members eligible for service retirement on or after January 1, 2001, to retire and begin accumulating retirement benefits without terminating employment.

Third Party Claims Processor (TPCP): The contractor retained by EIP to receive, process and pay claims under a plan.

Transfer: A transfer is any active employee who moves from one state group entity to another with no break in insurance coverage or no more than a 15-calendar-day break in employment. Academic employees who complete a school term and move to another academic setting at the beginning of the next school term also are considered transfers. A transferring employee is not considered a new hire for insurance program purposes. At the time of transfer, an employee will transfer to his new entity with the same insurance programs in effect with his previous entity as any other continuing state insurance group employee.

Trust: A holding of property placed by a grantor with a trustee for the benefit of a beneficiary. A trust may designate more than one beneficiary.

Trustee: The person who is given legal title to the trust property and who is obligated to administer the trust in accordance with the directions of the grantor (the person creating the trust).

Waiver of Premium Provision: The health insurance premium for a covered, surviving spouse and/or covered dependents of a deceased active or retired employee will be waived for one year from the date of the active or retired employee's death. The deceased's employer must have been making an employer contribution to premiums at the time of death. A covered spouse who is also a state employee is not considered a survivor for insurance purposes and the premium waiver will not apply. The Optional Life premium may be waived in the event of disability. SLTD and LTC premiums may be waived in the event of a disability provided claims status is established.

State Insurance Benefits Program History

Health Insurance Benefits

JUL 1, 1972 The SHP is initiated under the auspices of the state Personnel Division. Only state agencies are under the program. BCBS is the carrier at risk for the Plan.

SEP 1, 1974 A majority of the public school districts join the program.

JUL 1, 1975 The remaining public school districts are added.

OCT 1, 1975 Plan C is added to the health contract. It is designed as a catastrophic plan for people with other group coverage.

JUL 1, 1977 The first HMO, Piedmont Healthcare, is offered as an alternative to State Health Plan coverage. Piedmont Healthcare is available to state agencies and public school districts within a 30-mile radius of Greenville, South Carolina.

JUL 1, 1978 Plan C is eliminated.

APR 29, 1979 A minimum of five years of state service is required for retirees to be eligible for health insurance.

JUL 1, 1980 The state begins to pay the retiree health insurance premium in full. Drug and nursing and/or major medical coverage changes from optional to automatic.

The health contract changes to a modified administrative services only contract.

The active health program changes the maximum lifetime benefit from $50,000 to $250,000.

Chiropractors become covered providers for the health plan.

JUL 1, 1981 A pre-existing condition provision is added to the state health contract.

FEB 1, 1982 The state policy adds Plan B, expanded coverage, to the retiree policy. Retirees entitled to Medicare cannot enroll in Plan B.

JUL 1, 1982 The lifetime maximum for major medical for active employees is raised from $250,000 to $500,000.

The state-sponsored wellness program (Carolina Healthstyle) begins in Richland and Lexington counties on a pilot basis.

JUL 1, 1983 TEFRA regulations are introduced.

An optional second opinion service, mandatory pre-certification on 25 surgical procedures, and pre-admission testing for outpatient surgery are established for the State Health Plan.

The Plan A Medicare Supplement becomes the only available coverage for retirees eligible for Medicare.

JUL 1, 1984 The State Health Plan becomes fully self-insured, meaning that the state is liable for the health plan.

The State Treasurer begins controlling claim reserve funds and investment functions.

Eligibility rules for retirees become effective. Eligibility is predicated on the retiree having been formerly employed by an agency or school district for a minimum of five years.

HIAA screens are applied to professional charges under the State Health Plan.

JAN 1, 1985 Medicare is made secondary on dependents of active employees age 65 through 69 while covered as dependents under the state group.

Licensed clinical/counseling psychologists are recognized as providers of service when rendering care under their scope of practice.

OCT 1, 1985 In addition to HealthAmerica (Piedmont Healthcare), offered in the Greenville, South Carolina area since 1977, options to select HMOs are made available to agencies and school districts in most areas statewide during the open enrollment period. HMOs offered include Companion, HealthAmerica, Hospital Corporation of America and Physicians Health Plan (PHP). HMO coverage becomes effective December 1, 1985.

FEB 1, 1986 Retirees are granted an open enrollment period to select HMOs if desired.

APR 1, 1986 A federal mandate eliminates the age limit of 69 for TEFRA and DEFRA regulations. These regulations remain in effect during active employment.

JUL 1, 1986 Enrollment in Physicians Health Plan (PHP) proves more than the HMO can handle and approximately 18,000 employees are transferred back to the State Health Plan.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 mandated that employers with 20 or more employees allow extended coverage for 18 months for terminated or Reduction in Force (RIF) employees and for 36 months for widowed or divorced spouses, or ineligible dependent children. A rate of at least 100 percent of premium must paid monthly to extend coverage.

JUL 1, 1987 State-approved HMOs are required to have an affiliated general or family practice provider located within a 30-mile radius of subscribers in each county of the service area they apply to serve.

JAN 1, 1989 The Mammography Testing Program with a network of 22 participating facilities is introduced as part of the State Health Plan.

An employee drug card program is incorporated into the State Health Plan. Copayments are $7 for name brand drugs and $4 for generic drugs. Participating pharmacies bill the state directly for the remaining costs.

A voluntary employee advocacy and case management program (Medi-Call) is introduced as part of the State Health Plan.

SEP 1, 1989 - OCT 31, 1989 An open enrollment is held during which eligible employees can join the State Health Plan as late entrants without having to show medical evidence of good health.

JAN 1, 1990 The State Health Plan changes from a basic plus major medical benefits plan to a comprehensive benefits plan. The comprehensive plan requires coinsurance for services, with reimbursement based on allowable charges for the balance. The out-of-pocket maximum for individuals is $1,500 and $3,000 for the family. Once the out-of-pocket limit is met, the Plan pays 100 percent of the allowable charges.

The employee drug card program is discontinued. The program, expected to be revenue neutral, exceeded cost expectations by more than $12 million in 1989. Prescription drugs are once again treated as regular medical expenses subject to reimbursement after satisfying the deductible.

The comprehensive plan's lifetime maximum benefit is raised from $500,000 to $1 million.

Medi-Call, administered by Crawford and Company, becomes mandatory. If a subscriber fails to consult Medi-Call, the out-of-pocket does not apply and the employee is responsible for an additional $200 hospitalization deductible.

The Medicare Supplemental plan is discontinued. The State Health Plan continues to pay benefits secondary to Medicare according to the carve-out payment method.

Late entrants are required to show medical evidence of good health when applying to join the State Health Plan.

All employees and retirees are re-enrolled in order to bring records up to date.

JAN 1, 1991 Plan A is renamed the Economy plan and Plan B is renamed the Standard plan.

The Mammography Testing Program is expanded to fully pay for routine mammograms for female employees and retirees, dependents of employees and retirees age 35 through 74 who are State Health Plan subscribers.

The Pap Smear benefit is introduced.

The list of eligible providers for psychiatric, drug and alcohol abuse is expanded to include licensed professional counselors, licensed marital and family therapists, and licensed independent social workers. A psychiatrist or physician must make referrals.

The Medicare Supplemental Plan for retirees is restored.

Late entrants are allowed to enroll in the State Health Plan, the Medicare Supplemental plan or an HMO throughout the year by providing medical evidence of good health and being approved.

Retirees with Medicare are no longer required to pay a monthly premium for the Standard plan.

JAN 1, 1992 The State Health Plan Hospital Network is established. All general hospitals in the state participate in the plan and are paid a fixed price for most inpatient admissions.

The Maternity Management Program, an extension of Medi-Call, is established.

JAN 1, 1993 The State Health Plan Physician Network is established. Participating physicians agree to accept the State Health Plan allowable charge as payment-in-full.

BCBS becomes the new Medi-Call program administrator.

JAN 1, 1994 The State Health Plan Ambulatory Surgical Center Network is established with 20 ambulatory surgical centers participating in the network. The centers are paid a fixed price for their services.

Physicians Health Plan returns as an HMO alternative to the State Health Plan.

Dependents become eligible for coverage through age 24 if full-time student.

Expenses for services received from a licensed, independent nurse/midwife become covered expenses.

JUL 1, 1994 The State Health Plan Transplant Network is established. Three hospitals, the Medical College of Georgia, Medical University of South Carolina and Duke University Medical Center, sign on as participants.

OCT 1, 1994 Richland Memorial Hospital joins the Transplant Network for the transplantation of allogeneic bone marrow.

JAN 1, 1995 A penalty of $200 is added to the State Health Plan for failure to notify Medi-Call during the first trimester of pregnancy or refusing to participate in the Maternity Management Program.

The State Health Plan Prescription Drug Program is created. Medco Containment Services, Inc., administers the program. An additional and separate claim form is required for prescription reimbursement.

"Second surgical opinion" is revised to "second opinion." Second opinions are no longer limited to surgical cases.

Definition of nurse/midwife is expanded to include definition of extended role nurse.

Partial hospitalizations are allowed by the SHP if Medi-Call approves.

JAN 1, 1996 The Well Child Care benefit is added to the State Health Plan. The new program provides first dollar benefits for routine well child office visits and recommended childhood immunizations as outlined in the *Insurance Benefits Guide* and the *Plan of Benefits Document*.

MAY 1, 1996 The State Health Plan Appeals Process is formalized. The procedure is described in a brochure sent to all employees.

OCT 1997 Open enrollment is initiated for the 1998 benefit year. Subsequent open enrollment periods will occur in years ending in an odd number (1999, 2001) for coverage effective the following January 1 (2000, 2002). Annual enrollment will be held every year, during which only a change in health carrier may be made. Both annual and open enrollment periods may have announced additions and changes to programs other than health or dental. For example, an announced guaranteed issue for the Optional Life Insurance program.

Definitions of late entrant and pre-existing condition, as well as procedures associated with both, are changed to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

JAN 1998 The special annual and lifetime dollar limits for mental health benefits are removed effective January 1, 1998. Day and visit limits remain. Substance abuse treatment is still subject to a benefit year and lifetime maximum limit.

Effective January 1, 1998, $10 preventive worksite health screenings are offered to active employees.

Effective January 1, 1998, EIP expands its transplant contracting arrangements to include the Blue Cross and Blue Shield Association (BCBSA) National Transplant Network which includes more than 50 institutions nationwide.

All changes related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 become effective January 1, 1998.

JAN 1, 2000 The State Health Plan Prescription Drug Program is initiated. This "drug card" plan is administered by Merck-Medco Managed Care.

JUL 1, 2000 Legislation passed offering health benefits to permanent part-time teachers (working 19 to 29 hours per week) employed with South Carolina school districts, the Department of Corrections or the Department of Juvenile Justice. The health benefit does not include basic life or long term disability.

JAN 1, 2001 TERI effective date.

JAN 1, 2002 Effective January 1, 2002, CIGNA Healthcare is no longer a provider.

Effective January 1, 2002, HMO Blue is no longer a provider.

The State Health Plan implemented the Mental Health Parity with APS Healthcare, Inc., administering the program.

Upstate Partners HMO is available in the upstate to employees who work or live in the service area.

JUL 2002 Merck- Medco Manged Care becomes Medco Health Solutions, Inc.

State Dental Plan

FEB 15, 1985 Dental coverage begins. All active and retired employees with health coverage automatically are enrolled in dental coverage, with the exception of the Public Service Authority (Santee Cooper). Enrollment for dependent coverage is at the option of the employee/retiree.

JAN 1, 1986 Premium rates are increased by 8 percent. Premiums remain unchanged through 1995.

JUL 1, 1989 Dental fee allowances for 21 procedures in classes I and II increase 5 percent. The South Carolina Dental Association, as a recommendation to the state, identified the 21 procedures needing change.

JAN 1, 1990 Allowances for the same 21 procedures from classes I and II increase an additional 5 percent.

JAN 1, 1991 The fee schedule amounts for some allowable charges in the State Dental Plan increase. The procedures in class I not increased in 1990 increase by 5 percent. Procedures in class II not increased in 1990 increase 10 percent. Class III procedures increase 10 percent. Class IV orthodontic procedures remain unchanged for 1991.

JAN 1, 1992 Dental enrollment periods begins being every two years instead of annually.

The allowable charges increase for selected procedures in classes I, II and III based on the recommendations of the South Carolina Dental Association, or to the HIAA mean. Those procedures remaining in classes II and III increase an additional 6.7 percent. Class IV orthodontic benefits remain unchanged for 1992.

JAN 1, 1993 The allowable charges in classes I and II increase 3 percent. Class III allowances increase 10 percent. Class IV orthodontic benefits remain unchanged for 1993.

JAN 1, 1994 The allowable charges increase for several State Dental Plan procedures. Dental fee allowances increase 3 percent across the board for classes I, II and III. Class IV orthodontic benefits remain unchanged for 1994. The premium remains unchanged for 1994.

Dependents become eligible for coverage through age 24 if full-time students.

JAN 1, 1995 Dental fee allowances increase 3 percent across the board for classes I, II and III. Class IV orthodontic benefits remain unchanged for 1995. The premium remains unchanged for 1995.

Through the competitive bid process, Harrington Benefit Services, Inc., is selected as the third-party claims processor (TPCP) of dental claims.

JAN 1, 1996 The State Dental Plan fee schedule is revised to delete obsolete procedure codes and to update or add revised codes based on the American Dental Association-approved Current Dental Terminology CDT-2 manual.

JAN 1, 1997 An increase (from $9.80 to $11.71) in the employer share of the dental premium takes effect.

OCT 1997 Open enrollment is initiated for the 1998 benefit year. Subsequent open enrollment periods will occur in years ending in an odd number (1999, 2001) for coverage effective the following January 1 (2000, 2002). Annual enrollment will be held every year, during which no State Dental Plan changes may be made.

JULY 1, 2000 Legislation passed allowing qualified permanent part-time academic personnel (working 15 to 29 hours per week) access to state dental benefits with the premium based on the number or hours worked.

Dental benefits offered to permanent part-time teachers employed with South Carolina school districts, the Department of Corrections or the Department of Juvenile Justice.

JAN 1, 2002 Effective January 1, 2002, Dental Plus benefit added and administrated by R.E.Harrington.

Life Insurance Benefits

OCT 1, 1982 The voluntary optional term life insurance program is offered, with the initial contract with Metropolitan Life effective on this date. Premiums are based on age requirements and salary levels.

NOV 1, 1982 Optional Life coverage becomes effective for public school districts.

JAN 1, 1983 Optional Life coverage becomes effective for state agencies.

NOV 1, 1984 Optional Life Insurance coverage amounts increase 15 percent at no cost to those insured.

NOV 1, 1985 United of Omaha is awarded the Optional Life contract; rates are reduced; benefits are increased; and a maximum level of $80,000 coverage is added.

JUL 1, 1986 Year-round enrollment with medical evidence is instituted for Optional Life.

JUN 19, 1988 The Hartford is awarded the Optional Life contract, succeeding United of Omaha. The effective date of coverage is November 1, 1988.

OCT 31, 1988 The Hartford agrees to provide continuation of coverage to former state employees and retirees covered by United of Omaha under the portability option.

NOV 1, 1990 The Hartford cancels the portability policy extended to former United of Omaha policyholders, effective October 31, 1988. Members of the portability group are given the option of purchasing a new Optional Supplemental Life Insurance Plan, effective November 1, 1990, in increments of either $15,000 or $25,000. This coverage also is made available to retirees who had retired since November 1, 1988, and had Optional Life at the time of retirement.

JAN 1, 1991 Optional Supplemental Life becomes available to active employees.

JAN 1, 1992 Optional Life and Optional Supplemental Life premiums increase, with rates guaranteed not to rise for 22 months.

Employees purchasing Dependent Life insurance are offered $5,000 of coverage for their spouse and $2,500 for each eligible child age 14 days through 22 years. Those employees already covered under Dependent Life may keep their current coverage of $1,000 for their spouse and $1,000 for each child age 5 years through 22 years.

JAN 1, 1994 The Optional Life Plan is enhanced to allow continuation of 50 percent of coverage at retirement and to include a living benefit option, a seat belt rider and a premium waiver in the event of a disability. The Optional Supplemental Life Plan is no longer offered as an enrollment option.

Dependents become eligible for coverage through age 24 if full-time students.

Employees with $1,000 of Dependent Life coverage are allowed to increase their coverage level year-round by providing medical evidence of good health.

JAN 1, 1996 The $1,000 level of Dependent Life coverage is eliminated.

OCT-NOV 1996 During the annual enrollment period, an open enrollment for the Optional Life and Dependent Life programs is held. New enrollees can apply for the basic level of Optional Life coverage (based on their salary) and can select Dependent Life coverage of $5,000/$2,500 without providing medical evidence of good health.

JAN 1, 1997 New Dependent Life coverage levels are introduced: $10,000/$5,000 in addition to the $5,000/$2,500 coverage levels already available.

Retiring employees can continue their Optional Life Insurance coverage at 100 percent of the final face value of coverage, rather than the current 50 percent.

New maximum coverage for two salary brackets is added to the Optional Life program: $115,000 for salaries $70,000 to $79,999; and $125,000 for salaries $80,000 and higher. All other coverage levels increase $5,000.

OCT 1998 Those currently enrolled in Optional Life may select new benefit levels and options during the annual enrollment period.

Active employees already enrolled in the Dependent Life program may increase coverage by one level during the annual enrollment period without providing medical evidence of good health. Coverage will be effective January 1, 1999.

JAN 1, 1999 The maximum insurance amount increases one level for each salary bracket. New salary brackets take effect for upper salary levels. The same premium rate per $1,000 of coverage applies.

An employee retiring on or after January 1, 1999, may continue his Optional Life coverage into retirement at either 100 or 50 percent of the final face value of coverage.

An employee retiring on or after January 1, 1999, can maintain his Optional Life coverage to age 75, after which he may convert the coverage to a whole life policy.

The new option of $20,000 spouse/$10,000 child coverage is available in addition to the $10,000/$5,000 and $5,000/$2,500 coverage levels.

JAN 1, 2001 Dependent Life benefit divided into two separate programs: one for dependent children with the coverage level of $10,000. A separate benefit for the spouse allows $10,000 or $20,000 level of coverage without providing medical evidence of good health if requested within 31 days of first eligibility. The spouse's coverage level may be increased to 50 percent of enrollee's Optional Life coverage (spouse's maximum level is 50 percent of the employee's Optional Life level not to exceed $100,000) with medical evidence of good health.

Optional Life coverage tiers deleted. Optional Life levels not evenly divisible by 10 rolled up to the next $10,000 increment. New maximum level is $300,000. Level of eligibility no longer based on salary except selection as a new hire without medical evidence of good health (maximum is three times annual salary rolled down to the nearest $10,000 increment). Living Benefit Option now available for any amount up to 80 percent.

An employee retiring on or after January 1, 2001, may continue his Optional Life coverage in $10,000 increments up to the final face value of coverage.

JUL 1, 2001 Additional benefits added to Optional Life Accidental Death and Dismemberment (AD&D) at no additional cost: increased seat belt benefit from 10% to 25%; daycare benefit added; education benefit added; felonious assault benefit added. The same Optional Life AD&D benefits added to the Dependent Life/Spouse program at no additional cost.

NOV 1, 2001 No medical evidence of good health is required to add eligible dependent children to the dependent life/child(ren) benefit. Subscribers may elect to add dependent life/child(ren) coverage throughout the year or they may add eligible dependents children to the benefit. The 31-day rule no longer applies to this benefit.

MoneyPlu$

JAN 1, 1989 A qualified pre-tax flexible benefits plan (MoneyPlu$) becomes available. Benefits include insurance premiums, dependent care and out-of-pocket medical expenses.

JAN 1, 1990 The out-of-pocket Medical Spending Account feature of the MoneyPlu$ is discontinued due to federal tax legislation increasing the employer's liability for the benefit.

JAN 1, 1991 The Medical Spending Account is restored with a maximum benefit of $1,800. New employees and employees with less than one year of service cannot participate until they have been employed for one year.

JAN 1, 1994 LTC premiums become ineligible for deduction through the Pre-tax Group Insurance Premium Feature.

The Medical Spending Account limit increases to $2,400.

JAN 1, 1998 An employee no longer has to participate in the pre-tax group insurance premium feature to participate in the dependent care or medical spending accounts. An employee must be eligible to participate but does not have to enroll in a health plan to participate in MoneyPlu$.

JAN 1, 2000 Optional life premium for Optional Life coverage up to $50,000 will be exempt from tax for those who participate in the MoneyPlu$ premium pre-tax feature.

Medical Spending Account limit increases to $3,000.

Long Term Care

SEP 1, 1988 LTC coverage is offered to active employees and their spouses, with an effective date of January 1, 1989. They are not required to provide medical evidence of good health. The employees may pay premiums on a pre-tax basis through MoneyPlu$.

JUN 1, 1990 - JUL 31, 1990 An enrollment period for retirees was held. They were required to provide medical evidence of good health. The effective date for retiree coverage was January 1, 1991.

JUL 1, 1990 Parents become eligible for coverage subject to providing medical evidence of good health.

JAN 1, 1994 LTC premiums no longer can be deducted pre-tax through MoneyPlu$. EIP assumes responsibility for the billing and collection of LTC premiums.

Enhancements to the LTC plan include: an increase in the daily benefit options; modification of the pre-existing condition limitation; a two-year instead of five-year opportunity to purchase additional coverage (known as a "guaranteed issue"); and the right of spouses, parents and parents-in-law to enroll (with medical evidence of good health) even if the employee or retiree does not.

OCT 1994 A guaranteed issue is held in Fall 1994 for a coverage effective date of January 1, 1995.

OCT 1996 Aetna offers an opportunity to purchase an additional benefit unit of coverage on a guaranteed issue basis in October 1996 for a coverage effective date of January 1, 1997.

JAN 1, 1997 The daily benefit maximum coverage available increases to $140.

JAN 1, 1999 New lower rates take effect for those currently enrolled.

MAR 1999 LTC open enrollment period is held for active employees.

LTC guaranteed issue period is held for all LTC subscribers. All current subscribers may increase their coverage by $10 without providing medical evidence of good health.

APR 1, 1999 The maximum daily benefit amount increases to $150 from $140.

JAN 1, 2001 LTC guaranteed issue for all current LTC subscribers and spouses. Maximum daily benefit amount increases from $150 to $160.

APR 2001 LTC open enrollment held for active employees. New benefit effective June 1, 2001.

Basic $3,000 Life and Basic Long Term Disability

JUL 1, 1972 The Life and LTD insurance program is initiated. Pilot Life is the insurer for the LTD and $2,000 life insurance policy. The maximum benefit for LTD is $500.

JUL 1, 1974 The LTD maximum benefit increases to $600.

JUL 1, 1975 The carrier for life and LTD changes from Pilot Life to Liberty Life of Greenville, South Carolina.

JUL 1, 1977 A two-year waiting period is added to LTD for conditions for which treatment is received within six months prior to beginning employment.

JUL 1, 1978 The LTD waiting period for pre-existing conditions is changed from two years to one year.

NOV 1, 1979 The age limit on the life and LTD program for active employees is changed from 65 to 70 for payment of benefits as required by federal law.

JUL 1, 1984 - The life, accidental death and dismemberment and LTD contract is re-bid and awarded to Liberty.

JUN 20, 1997 Life Insurance Company. The maximum LTD benefit increases to 62.5 percent or $800 per month.

JUL 1, 1987 Administration of the life insurance, Dependent Life and LTD coverage is taken over by SCRS. In the past, the state contracted with an outside insurance company to insure this risk.

Life benefits for employees reaching age 70 on or after July 1,1987, are reduced by one half. Life benefits are not reduced for employees who reached age 70 before July 1, 1987.

NOV 1, 1988 Dependent Life is made a part of the Optional Life program underwritten by The Hartford Life.

JAN 1, 1997 Management of the Basic Life and Basic LTD insurance programs is transferred to EIP from SCRS.

Standard Insurance Company of Portland, Oregon, the SLTD insurer, becomes the administrator of the Basic $3,000 Life and the Basic LTD programs.

JAN 1, 2002 The Hartford becomes the administrator of the Basic $3,000 Life.

Supplemental Long Term Disability

JUL 1995 The SLTD program begins. This employee-pays-all program is introduced to address a perceived gap in the state's benefits program. The bid for this insured program is awarded to the Standard Insurance Company of Portland, Oregon. The initial enrollment is for employees of state agencies and local subdivisions for a September 1, 1995, coverage effective date.

SEP 1, 1995 The SLTD program becomes effective for enrolled employees of state agencies and local subdivisions.

NOV 1995 An enrollment period is held for employees of school districts and higher education institutions for a January 1, 1996, coverage effective date.

JAN 1, 1996 The SLTD program becomes effective for enrolled employees of school districts and higher education institutions.

JAN 1, 1997 The first premium increase based on salary and age takes effect.

SEP 1, 2000 Standard Insurance Company of Portland, Oregon re-awarded bid. The benefits were increased and the rates were decreased.

APR 2001 SLTD open enrollment held for active employees. Coverage effective June 1, 2001.

Vision Care Program

JAN 1, 1993 The Vision Care Program begins. Participating ophthalmologists and optometrists agree to charge no more than $44 for a routine, comprehensive eye examination. Participating vision-care providers, including opticians, also agree to give a 20 percent discount on eyewear. There are no claims to file and no reimbursements.

JAN 1, 1999 The 20 percent discount no longer applies to disposable contact lenses.

JAN 1, 2001 Routine, comprehensive eye examination charge increased to $50.

General Administration

JUL 1, 1980 The eligibility ruling for health, life and LTD under the state program changes from a permanent, full-time employee working five months for 30 hours per week to a permanent, full-time employee working more than six months for at least 30 hours per week.

JUL 1, 1984 A rule change allows academic employees who completed a full school term to remain on the state group insurance until the beginning of the next academic year (August 31), provided they continue employment in an academic setting and make appropriate payment of their share of the premium. This affects health, state Life, LTD and Optional Life coverage.

AUG 1984 The state Personnel Division's name changes to the Division of Human Resource Management (DHRM). The Insurance unit becomes the Insurance Benefits Section.

MAY 14, 1985 SCRS assumes the responsibility of administering insurance benefits and the Insurance Benefits section is transferred from DHRM to SCRS.

JUL 1, 1987 The State Dental Plan and HMOs are included along with the State Health Plan in the continuation of coverage package offered to active state employees and/or their dependents who qualify for COBRA.

SCRS begins the process of changing the health, dental and HMO contracts from a fiscal year basis (July 1 - June 30) to a calendar year basis (January 1 - December 31). To accomplish that, the contracts are extended from 12 to 18 months, to run from July 1, 1987 to December 31, 1988. Benefits and rules are unchanged.

JAN 1, 1989 Counties become eligible for state insurance benefits. Participation by counties is voluntary and the state does not contribute toward premiums.

JUN 5, 1989 DIS is created. It brings together the Insurance Benefits Section from SCRS and the Insurance Reserve Fund from the Division of General Services. All insurance contracts are transferred to the new division, except the state Life and LTD coverage, which remains at SCRS.

JUN 1992 The Risk Management section is added to the existing Insurance Benefits Management and Insurance Reserve Fund sections of DIS.

JUL 1992 Existing legislation is consolidated to make the following entities eligible for state insurance benefits: counties; regional tourism promotion commissions funded by the Department of Parks, Recreation and Tourism; county mental retardation boards; regional councils of government; regional transportation authorities; alcohol and other drug abuse planning agencies; and special purpose districts created by acts of the General Assembly to provide gas, water or sewer service or any combination of such services. Participation is voluntary and the state does not contribute toward the premiums.

JUL 1994 Effective July 1, 1994, the Division of Insurance Services becomes the Office of Insurance Services (OIS).

Legislation is passed to include recreation districts and hospital service districts as special purpose districts. Municipalities, councils on aging and community action agencies also may participate in the state's plan of benefits. The state does not contribute toward the premiums.

JAN 1995 The definition of eligible employee is amended to allow members of municipal councils to be considered employees for purposes of the Plan if they receive a salary and participate in the South Carolina Retirement Systems.

MAR 1996 Municipal and county council members of participating entities with at least 12 years of council service are allowed to enroll as retirees at full cost provided the participating entity elects to allow coverage for former members.

FEB 1997 Risk Management section is discontinued and the wellness program is incorporated into the Insurance Benefits Management section.

JUN 1997 EIP implements transfer procedures through which a transferring employee is no longer considered a new hire for insurance program purposes.

JAN 1, 1998 New student certification procedures take effect. EIP sends a letter notifying the employee of a dependent turning age 19. The employee is responsible for certifying that the dependent is a full-time student and for notifying EIP when the dependent is no longer a full-time student. EIP conducts random audits to verify compliance.

JULY 1, 2000 Legislation is passed to include permanent part-time teachers as eligible for health and dental benefits (eligibility based on job description; premiums based on number of hours worked per week).

JAN 1, 2001 The Teacher and Employee Retention Incentive Program (TERI) allows SCRS members to retire and begin accumulating retirement benefits without terminating employment.

JUL 2001 OIS becomes the Employee Insurance Program (EIP).

JUN 2002 The Employee Benefits Division becomes a part of the newly created Department of Insurance Grants and Services (DIGS).

County Codes

1	Abbeville	17	Dillon	33	McCormick
2	Aiken	18	Dorchester	34	Marion
3	Allendale	19	Edgefield	35	Marlboro
4	Anderson	20	Fairfield	36	Newberry
5	Bamberg	21	Florence	37	Oconee
6	Barnwell	22	Georgetown	38	Orangeburg
7	Beaufort	23	Greenville	39	Pickens
8	Berkeley	24	Greenwood	40	Richland
9	Calhoun	25	Hampton	41	Saluda
10	Charleston	26	Horry	42	Spartanburg
11	Cherokee	27	Jasper	43	Sumter
12	Chester	28	Kershaw	44	Union
13	Chesterfield	29	Lancaster	45	Williamsburg
14	Clarendon	30	Laurens	46	York
15	Colleton	31	Lee	99	Out-of-state
16	Darlington	32	Lexington		

Overview of State Insurance Benefits and Programs

Health Insurance Benefits

State Health Plan

The State Health Plan (SHP & Plan) is a comprehensive plan. A majority of employers in the United States use this type of plan. The Plan offers maximum protection from catastrophic illness or injury worldwide, the freedom to choose which doctors and hospitals to use, and easy access for medically necessary care. The Plan also provides coverage for common medical expenses like:

- doctors' office visits (diagnosis and treatment);
- inpatient hospital care;
- outpatient hospital care;
- laboratory tests;
- prescription drugs;
- durable medical equipment;
- mental health services;
- extended care (skilled nursing, home health and hospice care);
- well child care;
- mammograms;
- Pap Smear Program; and
- preventive worksite health screenings.

Employees covered by the Plan (subscribers) can take advantage of the SHP provider networks. These include the: Hospital Network, Physician Network, Ambulatory Surgical Center Network, Prescription Drug Program, Maternity Management Program, the Mammography Testing Program, the Pap Smear Program and Well Child Care benefits, Medi-Call pre-certification review, worksite health screening benefit and free chronic disease workshops. The Plan also maintains contracting arrangements for transplant services.

The State Health Plan Hospital Network

All general hospitals in South Carolina and Augusta, Georgia, participate in the network. Participating hospitals do not charge Plan subscribers more than applicable deductibles and coinsurance. In addition, 17 out-of-state hospitals have agreed to accept SHP allowances and bill the patient for applicable deductibles and coinsurance only. Services at non-network hospitals are covered also, but subscribers using these hospitals may pay more.

The SHP has provisions for services at out-of-state hospitals when it is an emergency or when it is not practical for subscribers to receive services at a network facility. In these cases Plan subscribers pay only applicable deductibles and coinsurance.

Inpatient hospitalization must be certified through Medi-Call even when using a network hospital.

The State Health Plan Physician Network

This network is a participating network, not a preferred provider network. All qualified providers may participate. Plan subscribers have the freedom to see the physician of their choice. Benefits are paid for medically necessary services whether or not the physician participates in the network.

Network doctors accept SHP allowable charges as payment-in-full. If subscribers choose a participating physician, they will not be balance-billed beyond applicable deductibles and coinsurance for covered services. In addition, participating physicians file claims for Plan subscribers. Physician services are reimbursed on the basis of a statewide fee schedule developed from current market charges in South Carolina.

The State Health Plan Ambulatory Surgical Center Network

The Ambulatory Surgical Center Network includes 24 ambulatory surgical centers around the state and works just like the SHP Hospital Network. These surgical centers accept predetermined prices for covered services. If an employee has services performed at an ambulatory surgical center in the network, he will not be balance-billed. Also, the facility will file all claims.

As with the Hospital Network, medically necessary services at a non-network ambulatory surgical center are covered also, but employees are responsible for any amount more than the predetermined price.

State Health Plan Transplant Contracting Arrangements

EIP has transplant contracting arrangements that include the Blue Cross and Blue Shield Association (BCBSA) National Transplant Network which features approximately 50 institutions selected according to their ability to meet both quality and price requirements. Richland Memorial Hospital and the Medical College of Georgia are under contract as well.

The hospitals in the transplant network accept the Plan's prices as payment-in-full. Subscribers who receive transplants at one of these facilities will not be balanced billed. Subscribers are responsible for applicable deductibles and coinsurance only. In addition, these facilities file the claims.

All transplant services must be approved through Medi-Call. A subscriber must call Medi-Call before he is evaluated for transplant.

The State Health Plan Prescription Drug Program

The State Health Plan Prescription Drug Program is a drug card plan. You must use a SHP Drug Program participating pharmacy. Under the Prescription Drug Program, subscribers pay a set copayment, either $7 for generics or $22 for name brands, for a 31-day supply of their medications. If the allowable price of the prescription is less than the copayment amount, the subscriber pays the lesser amount. The pharmacy then submits the claim electronically and the Plan reimburses the pharmacy directly.

Subscribers no longer have to file claims. Prescription drug costs are now carved out of the major medical plan. This means drug expenses do not count toward the annual deductible or coinsurance maximum and do not accumulate toward the subscribers lifetime maximum benefit.

The drug program pays at 100 percent per individual after the maximum of $1,100 per individual per year (January 1 – December 31) out-of-pocket covered expenses have been met.

Medi-Call

Medi-Call is a pre-certification review process designed to make sure all employees covered by the SHP receive appropriate medical care in the most beneficial, cost-effective manner.

Employees covered by the SHP must call Medi-Call for pre-certification of all hospital admissions, outpatient surgery and certain other treatments. Participation in Medi-Call is mandatory. If a Plan subscriber does not make a Medi-Call in a required situation, he will be subject to penalties.

Maternity Management Program

The Maternity Management Program is part of Medi-Call. Participation in this program is mandatory. The program helps mothers-to-be covered by the SHP get necessary prenatal care.

Mammography Testing Program

The SHP Mammography Testing Program provides first dollar benefits (no deductibles or coinsurance) for routine mammograms for covered females at participating facilities. A list of participating facilities is in the *State Health Plan Provider Directory*.

Pap Smear Program

The Pap Smear Program benefit pays first dollar benefits for either a routine or diagnostic Pap test but does not include the office visit or other lab work.

Well Child Care Benefit

The Well Child Care benefit provides first dollar coverage (no deductibles or coinsurance) for routine well child care office visits and recommended immunizations as outlined in the *Insurance Benefits Guide* and the *Plan of Benefits Document*. This benefit is provided only when a SHP Physician Network physician renders services.

Prevention Partners

Prevention Partners is another benefit of the SHP. Prevention Partners can help you and your family establish and practice healthy lifestyles and positive self-care. Chronic disease workshops are available free to all subscribers and their families. They are routinely scheduled and held statewide. A worksite health screening benefit is available through Prevention Partners to active employees covered by the SHP. Employees pay only $15 for a comprehensive health screening designed to determine if they are at risk of developing diseases like hypertension and diabetes.

Prevention Partners sponsors a spring wellness walk, holds an annual Health at Work conference and conducts orientations and consulting at worksites. Prevention Partners also provides self-paced programs such as stress management, step counter and weight management software and back pain injury prevention, as well as a monthly mailing of health education materials. (Worksite Screening Request form, Page 181).

Mental Health Parity

Mental Health Parity will be administered by APS Healthcare, Inc. Claims for mental health and substance abuse will be subject to the same deductibles, coinsurance and out-of-pocket maximums as medical claims.

Health Maintenance Organizations

Employees may enroll in an HMO instead of the SHP; however, HMOs are not available in all areas of the state. Unlike the SHP, all HMO services are coordinated and/or approved by a primary care physician.

There are three HMOs offered as alternatives to the SHP in certain areas of the state: Companion HealthCare, Upstate Partners and MUSC Options. Detailed information about each HMO plan and its service areas can be requested from the respective HMO. See Page 191 for HMO service area information.

State Dental Plan

The State Dental Plan is available to employees at no charge; however, there is a small monthly premium to cover eligible dependents. An employee and all eligible dependents must enroll within 31 days of the date of hire, within 31 days of a special eligibility situation or during an open enrollment period (every two years).

Dental Plus

Dental Plus is a supplemental dental program. It provides a higher level of dental coverage at affordable rates for the same services under the State Dental Plan. Dental Plus subscribers must be enrolled in the State Dental Plan to take advantage of this benefit, and they must enroll in Dental Plus for the same level of coverage for which they are enrolled in the State Dental Plan.

Basic Life Insurance

Employees covered by the SHP or an HMO automatically have $3,000 in basic life insurance coverage. Additional coverage is available through the Optional Life and Dependent Life Insurance plans.

Optional Life and Accidental Death and Dismemberment Insurance

Employees can enroll in the Optional life Insurance Plan within 31 days of their hire date. Coverage in $10,000 increments up to three times an employee's basic salary or $300,000, whichever is less, can be selected without providing medical evidence of good health. Up to $300,000 in coverage can be selected in $10,000 increments by providing medical evidence of good health.

Employees retiring after January 1, 2001, may continue their coverage in $10,000 increments up to their active coverage level until age 75. Reductions in benefits begin at age 70. Retiree coverage does not include the Living Benefit, Accidental Death, Seat Belt Rider or Dismemberment provisions.

Dependent Life/Child(ren)

An employee can purchase $10,000 in Dependent Life insurance coverage for his dependent children. The monthly premium for this coverage is $1.50, regardless of the number of children covered.

Dependent Life/Spouse

An employee may cover his eligible spouse with Dependent Life/Spouse insurance in $10,000 increments up to 50 percent of the employee's approved Optional Life coverage or $100,000, whichever is less (medical evidence of good health is required

for Dependent Life/Spouse coverage greater than $20,000). Subscribers who refuse the Optional Life benefit or choose a level of $50,000 or less may cover the spouse at a maximum of $20,000.

MoneyPlu$

MoneyPlu$ offers three ways to help employees save money by using their pre-tax dollars to pay for group insurance premiums, dependent care and medical expenses:

- the Pre-tax Group Insurance Premium Feature;
- the Dependent Care Spending Account; and
- the Medical Spending Account.

An employee who signs up for any or all parts of MoneyPlu$ authorizes the state to deduct a portion of his pay before federal, state and Social Security taxes are withheld. This lowers the employee's taxable income so that he pays less in taxes.

Long Term Care (LTC)

Long Term Care is a wide range of personal services, such as help with eating, walking and dressing, provided to people suffering from a chronic disease or long lasting disability. Most health benefit plans and Medicare are not designed to pay for long term care expenses. Medicaid will cover those expenses only if and when a patient exhausts all other financial resources. The state's LTC plan covers what Medicare does not and picks up where the SHP stops - with custodial care. The LTC plan pays for personal health care services for people of all ages who suffer from chronic conditions whether provided in a nursing home, adult day-care center or their own home.

Basic Long Term Disability (BLTD)

Employees covered by the SHP or an HMO automatically have Basic LTD coverage. EIP manages this plan and Standard Insurance Company is the claims processor.

Supplemental Long Term Disability (SLTD)

Supplemental Long Term Disability (SLTD) plan, insured by Standard Insurance Company of Portland, Oregon, offers employees additional income-protection benefits during times of disability. Premiums for this voluntary benefit are paid by the employee and feature two benefit elimination periods. The 90-day period has a higher premium and offers a shorter lapse between the onset of a disability and the payment of benefits than the 180-day period.

Vision Care Program

The Vision Care Program offers employees, retirees, survivors and COBRA participants, and their dependents, discounted vision-care services. Participating ophthalmologists and optometrists throughout the state agree to charge no more than $50 for a routine, comprehensive eye examination. Participants also receive a 20 percent discount on eyewear purchased from a participating vision-care provider. The Plan does not cover disposable contact lenses.

The Vision Care Program is not associated with any state group health coverage. Participants do not file claims or receive any reimbursement from the Vision Care program. The Vision Care Directory showing participating ophthalmologists and optometrists can be found on the EIP Web site.

VISION CARE ELIGIBILITY, PROGRAM, PROVIDERS, CLAIMS

Eligibility

Eligible participants shall include all full-time or part-time active employees (employees of state entities, school districts and participating local subdivisions), retirees, survivors, and COBRA participants. Eligible dependents of the subscriber are also qualified to participate in the Vision Care Program. The subscriber does not have to participate in the State Health Plan or a health maintenance organization to take advantage of this program; however, in order to receive the Vision Care Program discounted prices, participants must use the SHP Vision Care Program plan as their primary insurance or pay for services rendered and file for reimbursement with their primary insurance carrier. Participants do not file claims or receive any reimbursement from the program. The program is not associated with any state health coverage. State-related identification to prove eligibility may be required by the provider.

The Program

The Vision Care Program offers discounted vision care services. Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than $50* for a routine comprehensive eye examination. Treatment must be performed within the scope of the license of the provider. However, the fee shall not include the arranging for special diagnostic or treatment services, consultations, laboratory procedures, or radiological services as may be indicated because of the ocular examination. The subscriber should consult the eye care provider for details on any of these services. There may be an additional charge for contacts because the fitting of contacts can require additional services. Participating providers, which also include opticians, have agreed to give a 20 percent* discount on all eyewear (except disposable contact lenses).

The routine, comprehensive eye examination should include at least the following services:

- complete ocular and medical history;
- visual acuity far and near, with and without glasses;
- tonometry;
- screening visual fields;
- refraction;
- external motility, biomicroscopic and dilated ophthalmoscopic examinations; and,
- initiation of diagnostic and treatment programs as necessary.

***These amounts are current but are subject to change. If needed, contact EIP for the current amount.**

Providers

Providers are available statewide. Providers are listed by area in the *Vision Care Program Provider Directory* (available on the EIP website). If a provider is not listed, call his office before making an appointment to assure he is a participant in the state's Vision Care Program. Although the directory lists providers who have agreed to participate in this program, the state does not endorse or recommend any eye care provider.

Claims

The Vision Care Program is a discount program. The subscriber should not file a claim to the program or receive any reimbursement for routine eye examinations or eyewear including contacts. However, active state employees who participate in the MoneyPlu$ Spending Account are eligible to file reimbursement claims with MoneyPlu$ for eligible vision care expenses.

Prevention Partners

Prevention Partners is another benefit of the SHP. Prevention Partners can help you and your family establish and practice healthy lifestyles and positive self-care. Chronic disease workshops are available free to state employees and their families. They are routinely scheduled and held statewide. A worksite health screening benefit is available through Prevention Partners to active employees covered by the SHP. Employees pay only $15 for a comprehensive health screening designed to determine if they are at risk of developing diseases like hypertension and diabetes

Prevention Partners sponsors a spring wellness walk, holds an annual "Health at Work" conference and conducts orientations and consulting at worksites. Prevention Partners also provides self-paced programs such as stress management, cholesterol reduction and back pain injury prevention, as well as a monthly mailing of health education materials.

Worksite Screenings

- The Prevention Partners coordinator or BA mails or faxes a Worksite Screening Request form (Page 181) at least six weeks in advance to schedule a worksite screening. The coordinator or BA must provide the date, location, earliest starting time and approximate number of employees wishing to be screened on the form;
- Prevention Partners contacts the screening provider to confirm the date and location;
- Prevention Partners sends a confirmation notice and implementation kit to the worksite;
- Employees taking part in the screening write a check payable to the screening provider and gives that check to the coordinator or BA;
- Coordinator or BA collects employees' checks for the $15 copayment and schedules appointment times. Coordinator or BA faxes check receipt form and appointment schedule to Prevention Partners for eligibility verification;
- On the day of the screening, the coordinator or BA gives the employees' checks to the screening provider. The provider processes claims for the additional charges;
- After the screening results are complete, the provider will deliver confidential, individual results in sealed envelopes to the worksite coordinator or BA;
- Questions regarding worksite screenings should be directed to Prevention Partners at 803-737-3820.

Hotline Numbers and Addresses

The Aetna
Long Term Care applications, claims and program information
1-800-537-8521

APS Healthcare, Inc.
Suite 200
Bethesda, Maryland 20817
301-571-0633
1-800-305-3720

Blue Cross and Blue Shield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605
Web site: www.southcarolinablues.com
Natural Blue Web site: www.healthyroads.com
State Health Plan claims and program information
1-803-736-1576 (Columbia)
1-800-868-2520 (Nationwide)
Medi-Call Precertification and Maternity Management Program
1-803-699-3337 (Columbia)
1-800-925-9724 (Nationwide)
TDD numbers
1-803-865-3132 (Columbia)
1-800-222-4243 (Nationwide)

Companion HealthCare
P.O. Box 6170
Columbia, SC 29260-6170
Web site: www.companionhealthcare.com
HMO claims and program information
1-803-786-8476 (Columbia)
1-800-868-2528 (Nationwide)

Harrington Benefit Services, Inc.
P.O. Box 268902
Oklahoma City, OK 73126-8902
Dental claims and program information
1-800-848-2025
TDD number
1-800-824-1716

The Hartford
The Siskey Building
4521 Sharon Road
Charlotte, NC 28211
Death claims only for Optional Life, Dependent Life Insurance and Basic Life programs 1-888-563-1124
Medical Evidence 1-800-331-7234
Program Information 1-888-803-7346

MUSC Options
PO Box 6170
Columbia, SC 29260-6170
HMO Inquiries:
1-800-821-3023

The Employee Insurance Program
P.O. Box 11661
Columbia, SC 29211-1661
Web site: www.eip.state.sc.us
Customer Services
1-803-734-0678 (Columbia)
1-888-260-9430 (Nationwide)

Retiree Outreach
1201 Main Street, Suite 950
Columbia, SC 29201
1-888-260-9430

South Carolina Retirement Systems
202 Arbor Lake Drive
P.O. Box 11960
Columbia, SC 29211-1960
1-803-737-6800 (Columbia)
1-800-868-9002 (Outside Columbia)

Standard Insurance Company
Group Benefits Department
P.O. Box 2800
Portland, OR 97208-9929
SLTD claims and program information
1-800-628-9696 (Nationwide)

Stanley, Hunt, DuPree, Rhine & Assocs., Inc.
MoneyPlu$
P.O. Box 16000
Greenville, SC 29606-0001
MoneyPlu$ Medical Spending Account and Dependent Care Account claims and program information
1-800-768-4372
Automated inquiry system for claims information
1-800-413-6706

The State Health Plan Prescription Drug Program
Medco Health Solutions, Inc.
PO Box 2026
Pine Brook, NJ 07058
Medco Health Solutions, Inc.:
1-800-711-3450
TDD number:
1-800-759-1089
Web Site: www.merck-medco.com

The State Health Plan Prevention Partners
1201 Main Street, Suite 920
PO Box 11661
Columbia, SC 29201
1-803-737-3820
1-803-737-0793 (Fax)
Web site: www.eip.state.sc.us

Upstate Partners
PARTNERS National Health Plans
5635 Hanes Mill Road
Winston-Salem, NC 27106
HMO inquiries:
1-800-942-5695

EIP Departments

Customer Relations Unit

The Customer Services Department provides information and assistance to benefits administrators and subscribers for all state group insurance benefits programs. Our insurance benefits counselors are responsible for answering telephone calls and written correspondence from benefits administrators and subscribers who have enrollment and insurance claims problems. They also conduct presentations for training classes and employee meetings on the state group insurance benefits programs. If a subscriber's insurance claim is denied, the insurance benefits counselors help guide the subscriber through the appeals process.

The Customer Services Department acts as the benefits office for state agency and school district retired subscribers and their dependents and COBRA subscribers. If an active or retired employee dies, the Customer Services Department helps the survivors continue their coverage and acts as the benefits office for the subscriber's spouse and his dependents. **If you have any questions about the Customer Services Department, please call 803-734-0678 or toll free at 1-888-260-9430.**

The Field Services Department's representatives provide the same services as the Customer Services Department but on a one-on-one basis with the benefits administrator. The Field Services Department is responsible for providing the benefits administrator with assistance in three areas: on-site visits, training and new group enrollment.

On-site visits — The Field Services Department counselors conduct annual cluster meetings with area groups. A letter will be mailed to each group approximately one month in advance with the date and time of the meeting. If a specific benefits administrator needs to cancel a meeting, the benefits administrator should contact the Field Services Department at 803-734-1724 immediately.

Training — The Field Services Department offers programs in the areas of employee orientation, pre-retirement, staff development and off-site facilitator training. Please call Field Services to arrange for a representative to participate in a benefits fair or in an employee insurance benefits workshop. **If you have any questions about any of the programs the Field Services Department offers, please call 803-734-0678 or toll-free at 1-888-260-9430.**

Financial Services Unit

The Accounting Department is responsible for the billing and collection of the premiums for health, dental, life, long term disability and long term care insurance programs. The Accounting Department maintains individual accounts for approximately 46,000 retired, survivor and COBRA subscribers and more than 440 group accounts with an enrollment of approximately 170,000 active employees.

There are five accounting representatives who are responsible for answering questions about each state covered groups' monthly billing statement. They answer billing questions about the individual accounts for retired, survivor and COBRA subscribers. They perform student eligibility audits.

The Audit Department is responsible for ensuring that all state-covered groups comply with the EIP enrollment and financial requirements. The Audit Department performs field audits for each state-covered group. At a field audit, an auditor visits the site and verifies the entity's employee insurance benefits files or other relevant information with EIP membership files.

The field audit gives the benefits administrator the opportunity to ask enrollment and financial questions. **For questions about the Financial Services Department, please call 803-734-1696.**

Operations and Insured Programs Unit

The Operations Department is responsible for the processing and the maintenance of subscriber insurance files for more than 440 state covered entities. Each entity is assigned a processor who is responsible for answering enrollment questions for benefits administrators and active subscribers.

The Operations Department conducts monthly training classes on enrollment procedures for benefits administrators and their staff. The Operations Department also conducts computer classes on on-line inquiry for state groups who have computer access to our subscriber files. **For questions about the Operations Department, please call 803-734-0614.**

The Insured Programs Department manages the contracts for the Basic and Optional Life Insurance, Long Term Care Insurance, MoneyPlu$, Basic and Supplemental Long Term Disability Insurance and the Vision Care Program.

The Insured Programs Department answers contractual questions on insured contracts and coordinates the appeals process for employees denied long term disability benefits. **For questions about insured programs please call 803-734-3569**.

Product Development Unit

The **Product Development Unit** develops and manages contracts related to the SHP, the State Dental Plan, the Prescription Drug Program and health maintenance organizations. It is responsible for solicitations performed under the terms of the state Procurement Code.

This Unit also receives and processes applications from local entities who are eligible, by enabling legislation, to participate in the state's Plan of Benefits, and maintains entity contract files for adherence to the plan's participation requirements.

The **Product Development Unit** staff answers contractual questions received from subscribers, vendors and other concerned parties.

The **Communications Department** is responsible for developing and producing written materials that describe and explain each of the state group insurance benefits programs. The department is responsible for benefits communication, training, evaluating customer satisfaction and coordinating strategies for quality improvement.

The **Communications Department** produces three newsletters. *Insight* is a publication sent to benefits administrators to inform them about changes to the state group insurance benefits program. *The Insurance Advantage* is published each year before the annual enrollment period in October. It is used to inform subscribers of the changes they can make during the enrollment period that will become effective for the next calendar year. *EIP News* is a publication that is produced for active employees on an as-needed basis. A copy is sent to each entities' benefits administrator with *Insight*. The benefits administrator is responsible for copying *EIP News* and distributing it to his employees.

The **Communications Department** is also responsible for revising the *Insurance Benefits Guide* and *The Benefits Administrators Manual*. In addition they produce promotional materials for new programs added to the state group insurance benefits programs.

Training is coordinated by **Communications** and includes the Insurance Benefits Training Program which is a series of classes that explain the features of each of the state group insurance benefits programs that are offered. Most of these classes are held in Columbia. The **Field Services Department** offers off-site workshops. These are scheduled at various locations around the state for those benefits administrators and off-site facilitators who cannot attend the classes in Columbia.

The **Communications Department** also coordinates the annual "Benefits at Work" conference. "Benefits at Work" is an enrollment training conference for benefits administrators and their staff to learn about the changes in the state group insurance benefits programs for the next year. It is held in August. **For more information about the Communications Department, please call 803-734-0578.**

Research and Statistics Unit

The Research and Statistics Department develops the capacity to analyze data from all third party administrators' reports. Such data, along with enrollment statistics from the Budget and Control Board's Financial Data Systems, are compiled into manageable reports from which the department can identify key elements for analysis of noteworthy trends in the insurance programs. These trends allow EIP to determine the cost of insurance benefits on an annual basis.

This department develops and implements special publications involving key issues facing the Office's insurance programs. The department also corresponds with other states and large private employers to receive and share information about the different insurance benefits offered to employees.

State Health Plan Prevention Partners

The State Health Plan Prevention Partners provides activities, programs and services that encourage health promotion, disease prevention and early detection of disease for all subscribers. Prevention Partners holds Chronic Disease Workshops and administers the State Health Plan Preventive Worksite Screening Services throughout the state.

The goals of Prevention Partners are to increase the knowledge of subscribers about health promotion and education topics, increase the number of subscribers practicing healthy lifestyle behaviors and to encourage the practice of early detection of disease. For information about Prevention Partners, please call 803-737-3820.

Retiree Outreach

Retiree Outreach now administers Retirement, Plus!, a state-sponsored education program to assist retirees and their families with retirement issues and insurance benefits coverage. The program also offers a network of the state's retired employees who are trained in Medicare benefits, state insurance options, claims assistance and other retiree services. This is a free service. For information about Retiree Outreach, please call 803-734-0678 or toll–free at 1-888-260-9430.

Communications Materials

As a BA, you not only administer benefits, but communicate them as well. It is through you that EIP communicates with employees. Through communication, you can increase an employee's knowledge and ability to make wise health care decisions. The more informed employees are about their benefits, the less time you will spend answering questions and researching information. Look on the EIP website to find many of these publications. We make it easier for you by providing communications materials such as "The Benefits Report" video.

"The Benefits Report"

This fast-paced video offers overviews of each of the insurance benefits EIP offers to state employees. With Lou Green as anchor and a host of EIP employees in other roles, this newscast is an effective, informative and entertaining tool. "The Benefits Report" is ideal for new employee orientation meetings.

Insight

Insight is a publication designed just for you. It contains information to help you do your job. Along with *Insight*, you will receive *EIP News* (when published), policy clarifications and procedure changes. Find both on the EIP website.

EIP News

EIP News is published periodically and relays in-depth and up-to-date information about the state insurance benefits program. *EIP News* looks like a press release. One copy of each release is mailed to you. *EIP News* is ideal for posting on bulletin boards around the office and off-site.

The Insurance Advantage

The Insurance Advantage is an annual newsletter published before the October enrollment period. It is for all state employees and describes any plan changes for the next year. You are responsible for distributing *The Insurance Advantage* to all permanent, full-time employees. EIP mails *The Insurance Advantage* to retirees, survivors and COBRA participants. *The Insurance Advantage* outlines enrollment information only and should not be distributed after December 31.

The State Health Plan Provider Directory

The *State Health Plan Provider Directory* is published annually and lists all the providers (physicians, hospitals, ambulatory surgery centers, pharmacies and mental health/chemical dependency facilities) that participate in a SHP provider network. The directory can be found on the Blue Cross Blue Shield website: www.southcarolinablues.com.

Insurance Benefits Guide

Every insurance plan EIP offers is described in this guide, which you are responsible for giving to all permanent, full-time employees. Be sure to keep enough copies of this guide on hand to distribute to new employees.

Insurance Benefits Training Catalog

Published annually each fiscal year, this catalog provides a description and schedule of each training class offered by EIP. The guide and listing of classes can be found on the EIP website.

The Vision Care Directory

Published periodically, this directory lists optometrists and ophthalmologists who have agreed to accept the state's vision care discount. The directory can be found on the EIP website.

Stock brochures

Produced periodically, these brochures provide a more detailed explanation of existing or new benefits.

Insurance Orientation and Education Handbook

Originally produced as a quick guide for BAs to use to enroll new employees, this handbook has evolved into an excellent step-by-step guide for new employees to review in preparation for making benefits choices at their orientation meetings. This handbook is updated annually.

State Insurance Benefits for Retirees Handbook

This handbook describes, from the retiree standpoint, all benefits programs offered by EIP. It is updated annually and should be given to employees who are approaching retirement. This book will prepare them to make informed benefits choices and decisions in retirement. This book is updated annually.

Avenues

This Prevention Partners newsletter is published three times per year for distribution to all state employees. *Avenues* focuses on health promotion, prevention and early detection of disease.

The Volunteer

This bimonthly publication is distributed to the EIP Retirement, Plus! Volunteers. EIP has volunteers in areas around the state who have resources and materials available to assist state retirees. This publication is sent to these volunteers to keep them informed about SHP and Medicare issues and the scheduled Retirement, Plus! Workshops.

"Benefits at Work" Conference

Held each August, this annual enrollment training conference is for benefits administrators and their staff to learn about the changes in the state group insurance benefits programs for the next year. Pertinent insurance related issues are also discussed. The program consists of various workshops designed to be informative and helpful to the benefits administrators. Each entity is notified during the summer of the dates of the conference, required fees, hotel accommodations and topics for the workshops. This conference is instrumental in keeping benefits administrators and their staff abreast of program changes. It is also an excellent opportunity to meet the EIP staff and carrier representatives.

Educational Campaign Materials

Educational campaigns emphasize a particular benefit or introduce a new benefit. Campaign materials may include a poster and brochure. You also may receive presentation materials and computer software.

The Components of a Sample Educational Campaign

Educational campaigns are produced to emphasize an existing benefit or to introduce a new benefit. A description of the components you may receive for such a campaign follows:

- ✓ **Articles in *Insight***
  - Articles are published in *Insight* to give you advance notice of each campaign.
- ✓ **Articles in The Insurance Advantage**
  - If the timing of a campaign coincides with the distribution of *The Insurance Advantage*, an article explaining the benefit is included.
- ✓ **Articles in *EIP News***
  - *EIP News* is published periodically and provides in-depth and up-to-date information about a particular benefit or program. *EIP News* can be posted on bulletin boards around the office and off-site.
- ✓ **Poster**
  - Posters are a constant reminder of a new or emphasized benefit. You will receive plenty of posters for your location and your offsite locations. Always post these in common areas around the worksite(s).
- ✓ **Brochure**
  - Brochures contain complete details about the benefit. You are responsible for giving a brochure to each permanent, full-time employee and to all new employees.
- ✓ **Presentation materials**
  - EIP may provide you with a speech, slide show and/or videotape, depending on the type of program. You are responsible for conducting employee meetings for any new program or to emphasize an existing program; and
  - The Benefits Report video – updated annually for new employee orientation and fall enrollment meetings.

Educational campaigns may vary in components, but the premise is the same: to provide regularly scheduled reminders prior to the implementation of a new program or the emphasis of existing programs. With any materials you receive, you will receive instructions on how to use them.

Employee Meetings

When planning employee meetings, remember that you must either invite EIP staff to present information about the SHP and other insurance benefits programs, or present the information yourself. Also, if you would like representatives of the HMOs in your area to attend, you are responsible for inviting them. You must initiate any contact with an HMO. HMOs are not allowed to initiate contact with you.

The Insurance Benefits Training Program

The Insurance Benefits Training Program is a series of classes that explain in detail the benefits programs offered by EIP. The classes are designed to help you better inform and counsel employees about their insurance coverage and retirement benefits.

Benefits administrators, human resources/personnel staff, benefits staff and accounting/payroll staff are encouraged to attend. The "Insurance Benefits Training" class is a prerequisite for all other classes.

Class size is limited to 12 people with the exception of the Insurance Benefits Training classes, which are limited to 16 people. The classes are small so everyone attending has an opportunity to interact with representatives from EIP and ask the questions you need answered. In all classes, you will get hands-on experience working on sample exercises such as completing forms. Most classes are held at EIP in Columbia except for the off-site facilitator classes that are held in other cities. There is no cost to attend the classes, however, you may incur parking and meal expenses.

Some of the classes offered include:

- Insurance Benefits Training;
- Accounting;
- On-line Inquiry Training;
- Disability and Death Claims;
- MoneyPlu$;
- COBRA;
- Retirement Insurance Benefits Options; and,
- Prevention Partners Worksite Coordinator Training.

For more information on these classes, or for registration information, please call 803-734-0489 or toll free at 1-888-260-9430.